

# The role of gender, sexuality and context upon help-seeking for intimate partner violence: A synthesis of data across five studies

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## Introduction

Programmes of research which combine related studies are increasingly commonplace, including in the field of intimate partner violence (IPV). Yet data from individual studies that make up a programme of work are rarely systematically brought together and usually not included in a meta-synthesis of data. A Programme of Research on Violence in Diverse Domestic Environments (PROVIDE) is a UK National Institute of Health Research funded programme which ran between October 2009 and September 2014 (Funders Report 2014). The programme was divided into four workstreams which built on previous work conducted by members of the research team. Workstream 1 (WS1) built on and used insights from previous work looking at male perpetrators of domestic violence (Hester et al., 2006), on women's help-seeking in GP surgeries, and on the IRIS study (Identification and Referral to Improve Safety of women experiencing domestic violence) (Feder, Davies, Baird, Dunne, Eldridge, Griffiths, Gregory, Howell, Johnson, Ramsay, Rutterford, Sharp 2011). This workstream considered the prevalence of domestic violence in men attending general practice surgeries, and the healthcare responses to these men. Workstream 2 involved a randomised controlled trial of a psychological intervention delivered by specialist IPV advocates (Psychological Advocacy Towards Healing: PATH). This built on previous work including the LARA project (Trevillion, Byford, Cary, Rose, Oram, Feder, Agnew-Davies, Howard 2014) which had looked at the prevalence and experiences of IPV for those with mental disorders and how health services should respond to these. Workstream 3 (WS3) involved a cross-sectional survey and qualitative study in order to examine the impact of IPV on men who have sex with men (MSM) and to develop a pilot intervention for sexual health practitioners to promote enquiry about experiences or perpetration of domestic violence and to improve management after disclosure. The final workstream (WS4) of which this paper forms a part, involved the meta-synthesis of data from across the wider programme.

Thus, the five studies associated with PROVIDE are sited in general practice (IRIS, WS1), sexual health clinics (WS3), mental health services (LARA) and 3rd sector domestic violence agencies (PATH) (See Table 1). The topics range from the prevalence of domestic violence in health care settings, mental health care responses for women and men as victims, health care responses for men as victims or perpetrators and improving outcomes for women seeking help from domestic violence agencies with a psychological intervention. PROVIDE offered a unique opportunity to conduct a meta-synthesis of data across the programme in order to explore variations in help-seeking strategies between different groups according to gender and sexual orientation as well as variations in help-seeking across a range of healthcare and advocacy contexts.

### **What we already know about help-seeking in the context of IPV**

The health impacts of domestic violence and abuse are well known (Ellsberg, Jansen, Heise, Watts 2008). In a systematic review of associations between intimate partner violence (IPV) and health in men who have sex with men (MSM), one study found that 'exposure to IPV as a victim is associated with increased odds of substance use, depressive symptoms and being HIV positive' (Buller, Devries, Howard, Bacchus 2014. P.7). Systematic reviews of associations between IPV and mental disorders find that, across the diagnostic spectrum, women and men with mental disorders report a high prevalence and increased odds of being a victim of IPV compared to those without a mental disorder (Khalifeh, Oram, Trevillion, Johnson, Howard 2015; Howard, Oram, Galley, Trevillion, Feder 2013; Bundock, Howard, Trevillion, Malcom, Feder, Oram 2013). Yet health care professionals have only recently acknowledged their role in supporting those who are experiencing IPV (Peckover 2003) and rates of identification remain low across health care settings (Feder, Davies, Baird, Dunne, Elridge, Griffiths Sharp 2011). Women and men report numerous barriers to disclosure of IPV in the absence of direct questioning from health care professionals (Rose, Trevillion, Woodall, Morgan, Feder, Howard 2011) and two recent meta-syntheses highlight differences in the health care experiences of service users disclosing IPV in primary and community settings compared to mental health care settings (Feder, Hutson and Ramsay 2006; Trevillion, Hughes, Feder, Borschmann, Oram and Howard 2014).

Women are more likely to seek help than men in relation to IPV health-related issues however as Liang, Goodman, Tummala-Narra and Weintraub (2005) point out, women's understandings of their own experiences of violence have a bearing on whether they seek help at all, and from whom (ibid). The response received when women do seek help have a further impact on their understanding of their own experiences and on whether they attempt to seek further help. For those that do seek help, research studies show that heterosexual women who experience IPV tend to seek help from a range of formal sources including the police, counselling, social services, medical professionals and specialist services, as well as family and friends (Evans and Feder 2015). Lesbian women while also seeking help from friends and counselling services, were less likely to seek help from family, the police or medical professionals (Turell, herrrmann 2008). There has been less research and consequently less understanding about men's help-seeking in the context of IPV (Bacchus, Buller, Ferrari, Brzank, Feder 2016). There is some evidence however to suggest that men who experience potentially abusive behaviours (either as victims and/or perpetrators) do tend to see their health practitioners, however are unlikely to disclose the abuse (Williamson, Jones, Ferrari, Debonnaire, Feder, Hester 2015).

Some argue that this lack of disclosure may be because the 'masculine stereotype does not allow help-seeking, even if help is needed and could be available' (Muller-Leimkuhler 2002, p.6). Studies which conclude that masculinity is an influence in relation to men's lack of help-seeking, tend to focus

on homogenous samples and ignore factors such as socio-economic status and ethnicity (Galdas, Cheater and Marshall 2005). Thus, while masculinity cannot be discounted as an important factor, there should be more investigation into 'whether there are masculine commonalities between men, and how these are played out under different social circumstances' (Galdas, Cheater, Marshall 2005, p.261).

The aim of this paper is to undertake a cross-case analysis, in the form of a meta-synthesis of qualitative data from studies associated with PROVIDE. In exploring barriers and facilitators to help-seeking across the various studies, the meta-synthesis is intended to inform the development of training and support, specifically for healthcare professionals in relation to IPV and seeks to answer the following research question: How does gender, sexuality and clinical context (primary care/sexual health/mental health/voluntary sector) inform help-seeking in the context of intimate partner violence (IPV)? The meta-ethnographic approach was chosen because it can undertake critical examinations of 'multiple accounts', undertake 'systematic comparisons of case studies to draw cross-case conclusions', and facilitate ways of comparing and talking about studies (Noblit and Hare, 1988, p.12-13).

## **Methods**

Meta-ethnography sets out to not reduce the results but to widen the interpretation of the results (Kärkkäinen, Bondas, Eriksson 2005). In a 'traditional' meta-ethnography, this would usually involve examining published material relating to a specific research question. Since Noblit and Hare (1986) first published the methods of meta-ethnography as an approach to synthesis there have been various interpretations of their work (Kinn, Holgersen, Eke; and, Davidson 2013). For this article, published papers were not available on all five studies being synthesized. Instead we had researchers from each of the five studies on the research team and access to the coded and uncoded datasets. It seemed a timely opportunity to move the field forward by making use of the raw data whilst still adhering to Noblit and Hare's systematic approach for synthesis. One methodological implication of using meta-ethnography in this way is that we challenge the way meta-ethnography has increasingly come to be written about as a methodological technique to synthesising qualitative research. Noblit and Hare (1988) warn against viewing meta-ethnography as a methodological checklist. Instead, they encourage viewing meta-ethnography as "not a technique, rather it is a perspective and attitude that uses many techniques... an interpretative approach to social explanation" (p.25/15).

### Inclusion/exclusion criteria

Across the five studies to be included in the synthesis, there were a total of 116 separate interviews before exclusion criteria were applied (see Figure 1). Inclusion criteria included interviews: where the participant discussed being either a victim or perpetrator of IPV, where the focus was on help-seeking (rather than interventions) and where the participant described violence from an intimate partner (not a family member). We identified thirteen 'grey' cases. Although survey data (used in WS3) was not included in the meta-ethnography, we were aware that survey responses did not always match the interview data. For example, a survey respondent might have declared no experience of IPV and yet described such behaviours in his interview (or vice versa). In these cases, the research team privileged the interview data over the survey responses. Other 'grey' cases included those where one or more incidents of potentially abusive behaviours were described but the participant did not see them as abusive. For these, it was decided that where more than one incident was described and/or where the participant described impact such as fear, irrespective of whether or not he defined these behaviours as constituting IPV, then these interviews would be included. Therefore, interviews with one-off incidents and no impact were excluded from the meta-ethnography. All grey cases were discussed by the research team. After all criteria had been applied, we were left with 70 interviews to be included in the meta-ethnography (see Table 1).

(insert table 1 and figure 1 here)

### Synthesis

Noblit and Hare (1986) describe a systematic approach to synthesis, involving seven clear stages (see figure 2). The first two stages involve deciding what is relevant to the meta-synthesis aims and objectives. Unlike a traditional meta-ethnography the research team had individual knowledge of their data sets and decided to focus the meta-synthesis on four aspects of help-seeking: Barriers to help-seeking; Facilitators to help-seeking; Informal sources of support (family and friends); Formal sources of support (health practitioners; police).

Lee, Hart, Watson and Rapley (2015) have scrutinised the variety of ways of enacting Noblit and Hare's seven step process. Stage three, involves reading the studies in detail and identifying metaphors and assessing the adequacy of metaphors. This may involve organising the studies into groups and coding themes (Lee, Hart, Watson, Rapley 2015). Stage four involves determining how the studies are related by listing and juxtaposing metaphors for each case. This may involve identifying common and recurring concepts, listing original 'key concepts' and the relationship between them, for example by mapping key concepts within groups of studies (Lee, Hart, Watson, Rapley 2015). Stage five is the translation of one study into another. This involves pre-serving the within-study relationships between metaphors whilst comparing across studies. In practice it means reviewing each study for the presence or absence of key concepts and maintaining the original language and concepts used in the studies. Stage six

involves synthesising the translations, this may involve looking for relationships between key concepts and studies (Lee, Hart, Watson, Rapley 2015). Stage seven is the expression of the synthesis and usually takes the form of a publication. As Lee, Hart, Watson and Rapley (2015)'s work points out these seven steps have been interpreted and conducted in a range of ways –reinforcing Noblit and Hare's intention that meta-ethnography become a perspective and attitude that uses many techniques rather than a reductive checklist.

In this synthesis, stage five involved KM reading the raw interview data using the Framework Analysis facility on NVivo10. Each interview was entered in a separate row (creating 70 rows), with columns representing our four areas to be explored in the data. In relation to each interview, the first order constructs (verbatim quotes), were placed in the appropriate cells. Stage 6 involved the synthesis of these translations – a process conducted by the first author and clarified in discussions with AM and EW. This enabled us to develop the third order constructs – 'interpretations or conclusions of the meta-synthesis of primary studies' (p.24) (Feder, Hutson, Ramsay, Taket 2006). The third order constructs represent our interpretive readings of help-seeking across the five studies.

For the synthesis of 2<sup>nd</sup> order constructs, we found that the studies generally could be arranged into two internally consistent groups along gendered lines. The synthesis provides a 'hermeneutic or explanatory level' (Ricoeur 1981, p.82) whereby it becomes necessary to refer to the whole to understand the parts and the parts to understand the whole (Ricoeur 1981). In this context it enables us to 'construct an overarching narrative' (Noblit and Hare 1988, p. 64) of help-seeking for IPV across all five studies. These syntheses are discussed in more detail below, however first we set out the findings in relation to the second order constructs.

## **Findings**

Details of the studies included in the synthesis are reported elsewhere (NIHR Report 2014). The studies included in the synthesis collected their data from primary care (IRIS, WS1) mental healthcare settings (LARA), specialist IPV agencies (PATH) and sexual health settings (WS3). Table 1 (above) describes the number of interviews from each study as well as the gender and age range of the participants within each study. We identified 23 2<sup>nd</sup> order constructs in relation to help-seeking across the five studies included in the synthesis. Table 2 lists the 2<sup>nd</sup> order constructs and the studies in which they appear. We now explore each 2<sup>nd</sup> order construct in turn, with at least one verbatim example.

### **Barriers to help-seeking**

The synthesis identified six 2<sup>nd</sup> order constructs across the studies that relate to barriers to help-seeking.

### *Hard to talk about abuse*

Of all 23 second order constructs, only one construct 'Hard to talk about the abuse' was repeated across all five studies. Men and women found it difficult to tell anyone about the abuse they experienced (or in a few cases, perpetrated). This difficulty extended to both formal and informal sources of potential support. In some cases men and women did not want to be forced to have to think about the abuse: *'I just don't want to talk about it no more'* (LARA: 13). For men across WS3, but also for one or two in WS1, their sexuality was an additional barrier to talking about abuse. Even where the men were openly in same-sex relationships, they felt that any attempt to seek help was pointless: *'I could imagine someone say: "Oh well, what do you expect?"'* (WS3 Pilot: 70). Underpinning this was the belief that only women can be 'victims' of IPV. If men cannot be victims, then IPV cannot occur in same-sex relationships. Privacy was particularly important to men in WS1 and WS3 which compounded any reluctance to talk about IPV they had experienced or perpetrated. Privacy was linked to stereotypical discourses of masculinity: *'Well I'm like a man; I haven't told them nothing about it'* (LARA: 22) because it's just *"too private"* (WS1: 53).

### *Denial or normalisation of abuse*

Women in three of the studies: IRIS; LARA and WS3 indicated that IPV was not always recognised because it seemed to be a 'normal' feature of their relationship – or of relationships in general. For example, it was felt that the perpetrator was not someone who could be described as a 'perpetrator' but could be described as a 'bully': *'I mean he is educated, he works for a radio [station] [he's] not the [IPV] type'* (IRIS: 4). For men in WS3, some element of aggression was normalised as *'part and parcel of [...] being in a relationship with another man'* because there was *'too much testosterone flying about'* (WS3: 58) – yet they did not necessarily perceive themselves as having been in an abusive relationship. One male participant linked his lack of understanding about whether IPV was 'normal' in MSM relationships with wider normalising perceptions: *"I could imagine someone say, 'Oh well...it all goes with the territory'. [Be]cause I didn't really know what the territory was [either]"* (WS3:70).

### *Self-blaming*

Four studies in the synthesis (LARA, IRIS, PATH, WS3) described self-blame as a barrier to help-seeking: *'it becomes your problem and you really feel it's you; the more they hit you the more you convince yourself it's you'* (LARA: 30). Other women, especially in IRIS and PATH felt that they deserved what had happened to them – for example, *'I'd driven him to it'* (IRIS: 2) – thus there was no point in approaching anyone for help. Some men also self-blamed: *"I felt responsible for it"* (WS3:70).

### *Fear of consequences*

Another key barrier, across four of the five studies IRIS, LARA, PATH, and WS3, was fear of the consequences of disclosing. Women feared escalating the abuse: *“the police they don’t understand they think an injunction is the answer but they don’t understand the repercussions...they haven’t got a clue, women are afraid of the consequences”*(PATH: 33). There was also the fear of being seen as ‘weak’ by friends or family: *“I didn’t want to be seen weaker than anybody else. Cause I see myself as an independent person. (Friends and family) would see me as not standing up for meself”* (LARA:19). Similarly for men in WS1: *‘you just don’t want your best friend to think, “God his life’s all so awful”* (WS1:56). Only women mentioned the fear of having children taken away. Women in the LARA study reported additional concerns that because of their mental health problems they would be viewed as unable to be the primary caregiver to their children: *“I used to go to the family centre for a visit and they used to say ‘oh he’s [abusive partner] got evidence against you to use’...to say ‘oh she’s mad, she got all these mental health diagnoses”* (LARA:14).

### *Abuser present at consultations*

For a few women in LARA, IRIS and PATH, the abuser was present at medical consultations (in one or two cases as the interpreter), thus making it more difficult to tell or be asked about abuse: *‘most of the time he [the perpetrator] would come in with me and obviously I can’t say this person is torturing me’* (IRIS:6).

### *Nowhere to get formal support*

For the men in WS1, there were relatively few barriers to help-seeking mentioned because they struggled to identify circumstances in which they might require help in relation to IPV. Men in WS3 described a lack of knowledge about services available: *‘[I] just never considered that there might be any help out there for’* (WS3: 67). It is noteworthy that this construct appeared in both general practice and sexual health settings but did not appear in any of the other three studies with women.

## **Facilitators**

The synthesis identified four 2<sup>nd</sup> order constructs under the theme of facilitators. Whereas barriers to help-seeking seemed more common across the studies included in the synthesis, with two or more studies sharing the same 2<sup>nd</sup> order construct, this was not the case for facilitators.

### *Severe Incident*



In the three studies with mainly women (IRIS, LARA and PATH), help-seeking was triggered by a major incident involving serious physical abuse. For example, for one woman it was not until *'the actual biggest thing happened'*, at which stage the police were involved, that she felt able to ring a help line for support (IRIS: 6). Another managed to escape when an attack meant that she had to be hospitalised and the abuser was picked up by the police (PATH: 41). For a third, it was when her partner tried to strangle her. That was *'the last straw'* (LARA: 15). For gay men in WS3, experiencing severe acts of violence led to termination of the relationship, circumventing help-seeking behaviour for IPV.

#### *Protecting children*

Women in IRIS, PATH and LARA were motivated to seek help by issues to do with their children: *'[h]e threatened my son. You threaten my son and that's a different story all together'* (IRIS: 10). One woman decided that she had to leave her abuser because of the effect she felt the abuse was having on her child (PATH: 38) while another decided to seek support after the abuser turned up and threatened her in front of her small child (PATH: 40). One woman explained that her son's poor behaviour made her realise that she needed support: *'I was thinking "oh maybe he's got a thing against women" 'cause he's seen his dad beating me up'* (LARA: 16).

#### *Behaviour of health professionals*

A key facilitator for participants in studies based in primary care and mental health settings (IRIS, LARA) was the way they were treated by medical professionals. This included being asked about the abuse, being provided with information or simply sensing that they were not being rushed by their GP or mental health clinicians: *'he don't rush you out of the surgery before you've just come in and sat down. He really understands'* (IRIS: 9). For men in WS3 they wanted health professionals to be non-judgemental.

#### *Reciprocity*

Reciprocity was an important facilitator in WS1. As one man said of his brother: *'he had some issues that he wanted to talk to me about [...] and then of course that allowed me the opportunity to open up [...] with him on certain issues myself...'* (WS1: 44). Another male participant described the quality of reciprocity with his brother: *'we were each other's confidants'* (WS1: 45). Reciprocity may be one strategy for overcoming masculinities that silence and prevent disclosure.

#### **Informal support: Family and Friends**

This theme generated seven 2<sup>nd</sup> order constructs across the studies. There was much less clustering around 2<sup>nd</sup> order constructs, with four of the seven constructs being linked to only one study.

#### *Turned to family after severe incident*

Two studies (IRIS, LARA) reported help-seeking from informal sources after a severe incident. For example, a woman who felt judged for remaining with the abuser called her sister and brother-in-law for help after one particular incident of physical abuse (IRIS: 11). None of the male participants discussed turning to friends and family after a severe incident.

#### *Protecting families and friends*

Women from the same two studies (LARA and IRIS) felt that they could not tell family members about the abuse they were experiencing because they were afraid of reactivity: *'they [my children] would have killed him [perpetrator]'* (IRIS: 5) Another woman did not tell her brother because he would have *'wanted to go down there and do him some damage'* (LARA: 16).

#### *Isolated from family and friends*

Despite wanting to inform family about what was happening, women in the PATH study were unable to do so because family did not live close by or because the abuser deliberately isolated the woman from her friends and family: *'No I wasn't allowed to see my family, he kept me away from everything'* (PATH: 41).

#### *Sexual identity as barrier to family and friends understanding*

Whilst men in either WS1 or WS3 rarely reported seeking professional support (and most indicated that they would be unlikely to), a barrier for informal support were concerns that family (especially parents) would not 'understand' the nature of IPV in a same-sex relationship. One man commented of his family: *'They wouldn't have a clue [about same-sex relationships]'* (WS3: 60). The assumption was that family and friends would not know what to recommend: *'I certainly wouldn't ask friends. Because I don't think any of them would have a clue actually [...]'* (WS3: 60). For other men, revealing IPV would also mean revealing their sexual identity: *'I have never told any of my friends...a lot of them didn't know that I was gay. And so it's hard to tell that story [of IPV] without revealing that fact'* (WS3:70). This construct links back to ideas of normalisation (above). If men imagined others viewed IPV as being part of the 'territory' of MSM relationships, this added another level of complexity in disclosing to friends and family.

#### *Empathetic*

Men in WS1 and WS3 tended to seek informal support from friends who often took on the persona of a 'brother' or 'uncle' figure. A key issue was that those they spoke to should be empathetic: *'the two*

*friends I speak to, one is like an older brother and the other is a very kind bloke and fairly empathetic...good at understanding people'* (WS1: 52). Help-seeking from friends who've had similar experiences was important: *'both [confidants] had been in sort of bad relationships as well. And knew what it was like'* (WS3: 66). Some gay men in WS3 seemed to differentiate between 'listening' advice which was supportive as opposed to more directional advice: *'[friends] would listen and give advice if I wanted. They were just there as a support really and to bounce off ideas and feelings'* (WS3: 59). This links into another construct that men in WS1 and WS3 identified, which was anticipating whether they would be challenged or not on their behaviour and decision-making.

#### *Non-challenging support*

Whereas women in LARA and PATH reported not being believed or supported by friends or family and sometimes judged, male participants reflected on the likelihood of being challenged on their behaviour. For example, one man reflected on his reluctance to confide any further with one particular friend, because the friend had previously posed *'a question I didn't wanna know the answer to'* (WS1: 44). Similarly, a man in WS3 who had friends prepared to challenge him, found this a barrier to approaching them for help: *'well I don't want to hear that'* (WS3: 69). He preferred to talk to his mother who would give non-judgemental advice. Another male participant noted that talking to friends involved confirming a decision already made (WS1: 46). Thus, friends were selected in the studies dominated by men, as confidants who would provide unchallenging and uncritical support:

*'If you want someone to make you feel better, then maybe the friends are the ones to go to. But if you want something to change and someone to tell you sometimes "you're the one, you're being an idiot" [then you get professional help]'* (WS3: 64).

#### *Asking for Help 'Causing Problems'*

We did not find examples of women in LARA, PATH or IRIS making similar distinctions between informal and formal sources of support. Instead women would not seek help from friends and family to avoid being seen as 'causing problems': *'You know, it's just that [my mum's] older now and I don't, I can't keep stressing her out'* (LARA:16). One woman sensed friends had withdrawn after she had confided in them: *'I felt that people very gradually started to withdraw from me because I was having the same problem over and over'* (PATH: 39). One woman noted that although a friend would offer her shelter *'it used to cause conflict for her'* (LARA: 16).

#### **Formal support: Health professionals**

This theme generated eight 2<sup>nd</sup> order constructs. The first five of these constructs relate to health professionals behaviour and only appear in the studies with women (LARA, IRIS, PATH). This may link once more to the construct under barriers-that men in WS1 and WS3 did not know where to go for formal support and so had little experience of it to report.

#### *Help from mental health teams*

Of the participants from the three studies with women, those from LARA were the least likely to have discussed IPV with medical professionals, and especially not with mental health staff. Participants across all five studies said they had not been asked about any abuse by mental health professionals. Professional help seeking for women in PATH, IRIS and to a lesser extent LARA was more focused upon primary care services. Professional help seeking for men was notable by its absence and mostly discussed as a hypothetical case, for example, men expressing a willingness to seek help from GUM clinics.

#### *Reluctance to disclose*

For some women in IRIS and PATH studies, their visits to the GP were because they wanted to be asked about abuse in their relationships, however most felt unable to volunteer the information and were disappointed that their GP did not take the initiative in asking. One of these women went to the GP because of back problems, wanting to be asked about the bruising, but the GP did not say anything: *'And I didn't feel comfortable to say, "Have a look at the bruise. This is what my boyfriend's done to me"'* (IRIS: 10). The failure to ask about abuse was even when the women were presenting with physical signs of abuse.

#### *Health professionals not initiating discussion*

When women from the IRIS and PATH studies attempted to raise the issue of abuse with their GP, especially for the first time, some women would euphemistically refer to being in a 'bad' or 'problem' marriage (IRIS: 2; PATH: 39). If the GP did not pick up on signs or ask specific questions about abuse, it left the women feeling confused: *'I felt like a prat'* and was *'really upset because they couldn't help me and I needed help'* (IRIS: 5). Not being asked made one woman think that maybe the abuse wasn't such a big deal after all (IRIS: 7). One woman said that she would go to her GP after being given black eyes or having her hair pulled out, and had told the GP that her husband had done it but *'it was just left at that'* (LARA: 25). Seeing GP's describe IPV injuries in their patient notes in neutral terms was extremely unhelpful: *'[...] I went to the doctor once and he'd [the abuser] punched me in the face, I was there like a scared rabbit [...] it doesn't take an Einstein to work out "hang on, this woman is being abused."' [...]* *I saw in my doctor's notes, "came in with scar on face"* (LARA: 28).

#### *Neither part of GP remit nor time in consultation*

Some women in IRIS believed it was not really part of the role of GPs to provide help regarding IPV. Several commented on the fact that GPs are allocated little time to talk to patients and 'so they rush you out' (IRIS: 8) or women view their GP as unwelcoming: 'Their faces when you walk in. Don't bother saying nothing.' So I'm in and out' (IRIS: 10).

#### *Once aware, usually helpful*

However, many women from IRIS and PATH found that their GPs were helpful once they were aware of IPV. One GP took some time before recognising IPV but immediately referred his patient to a specialist IPV service. Following this he would ask about the abuse '[w]hereas before he wouldn't. [...] I can't fault him. Every time I go in there he's, he asks me...he does want to help' (IRIS: 8). A woman from LARA presented in A&E with a broken foot from escaping her abuser and without disclosing abuse she was given some information on IPV:

*'It was such a turning point for me, reading that information and taking in the aspects of domestic violence, it was so powerful and I had to turn away from the staff and cried and cried. that was enough for me at that time. I just couldn't have dealt with them saying "this isn't on and we have to intervene" that would have just destroyed me...it was a turning point' (LARA,5).*

#### *Medicating abuse*

Women across IRIS, LARA and PATH frequently mentioned going to the GP because of anxiety and depression and being given medication rather than other support. A woman in PATH had visited the GP after being strangled, having presented previously with other injuries from IPV. Her GP did not offer any support other than medication for depression (PATH: 40). Medicating abuse was a common construct across IRIS and PATH. GP's were rarely aware that women may not be able to access the medication if the abuser controlled the finances needed to pay for prescriptions (IRIS: 4). Male participants were less likely to visit the GP for anything other than physical problems although a few did confirm that they had gone for help with anxiety and depression that was related to (non-disclosed) IPV and had been given medication. Again the underlying causes were not explored in the consultation.

#### *Sexuality and sex taboos*

Male participants on the whole had not turned to their GPs for help for IPV. For some of the WS3 men their sexuality was a barrier to discussing relationship issues as they had never discussed their sexuality with their GP: '[my GP] has known me for 30 years I don't think I would feel comfortable talking about my sexuality whatsoever. She knows my family, she knows my dad, and not just that, its just brrr' (WS3:63). Similarly, for some women the barrier to discussing abuse was about having never discussed their sex lives with their GP. One woman explained that although on the whole she felt that

her GP was supportive, *'I think there are elements of my relationship with my husband which it's difficult to say to my GP because it's to do with sex but that's just because he's a bloke'* (IRIS: 3).

#### *More likely to seek help from GUM clinics*

One of the key barriers to formal help seeking amongst men in WS1 and WS3 is that even when there were abusive behaviours in the relationship, men did not necessarily see this as IPV. When asked about seeking help from professionals, and especially from medical professionals, the question became a hypothetical one irrespective of their personal experiences. At this point men in WS3 indicated they would be willing to seek support from a GUM clinic because the staff were viewed as less judgemental and they valued the anonymity:

*'I think here [GUM Clinic] would be much better. I think the GP you don't get a sense of anonymity and confidentiality that you [get here]. You almost think that when you see a GP that everything is written down and that's going to be on your record for a very long time, so you're never allowed to forget your past, but whereas coming here the health workers here, are almost non-judgemental'* (WS3:65).

#### **Developing the Findings: third order constructs**

Having translated the second order constructs across all five studies, we used these to develop the third order interpretations in relation to help-seeking in the context of IPV. The second order constructs become the 'building blocks' of the 3<sup>rd</sup> order interpretations (Britten, Campbell, Pope, Donovan, Morgan, Pill 2002, p. 211). We have set out the third order interpretations in Table 3.

#### ***Barriers***

The synthesis developed three over-arching constructs to explain barriers to help seeking: internalised structural barriers, internalised homophobia and external structural barriers.

#### *Internalised structural Barriers*

Across IRIS, LARA and PATH, findings were consistent in almost all respects. In relation to barriers to help-seeking, we found that although there were minor differences between the second order constructs for these studies, these could all be subsumed under the over-arching theme of 'internalised structural barriers'. These are all barriers which exemplify the internalisation of specific societal attitudes such as victim-blaming, or the internalisation of abuse which might result in a lack of confidence, guilt and shame and in some cases may cause post-traumatic stress (Abrahams 2007). Such barriers tend to mean that victims of IPV may be inhibited from telling anyone about their abuse, or seeking either formal or informal support. In some cultures, there can be a climate of fear which 'generate[s] a state of self-censorship' in which individuals avoid talking in public and even monitor

their thoughts (p. 154) (Cohen 2001). A culture of IPV, seems to generate a similar level of self-censorship which, especially when coupled with a fear of potential consequences can create almost insurmountable barriers for victims of IPV. Furthermore, in the context of the micro-culture of a relationship, even if the abuse is recognised as such (which is by no means certain), women may stay in the relationship because 'it is easier to negotiate the effects of one individual "other" on one's subjectivity than to negotiate the reflection of multiple "others" (Williamson 2016, p.1417). This third order construct was shared by men in WS3. Again, there were internalised structural barriers such as finding it difficult to discuss abuse. Often this was because of the perceived normalisation of aggression in male-same-sex relationships and the heteronormativity of domestic violence. Within heteronormativity, domestic violence is perceived as happening between men and women, with men usually being the perpetrators. Men in WS3 internalised this heteronormativity making it difficult to identify the territory of IPV within same-sex partnerships.

#### *Internalised homophobia*

A factor for men in WS3 may have been 'Internalized Homophobia' (IH), the 'internalization of society's homophobic attitudes within a lesbian, gay or bisexual (LGB) individual' (Newcomb, Mustanski 2011, p.189). IH has been 'associated with violence against one's own group' (Balsam, Szymanski 2005, p.260). Although IH has generally been researched in relation to risky sexual behaviours, the effects on other health related outcomes have not yet been identified (Newcomb, Mustanski 2011, p. 189). In the context of this study and the general lack of recognition of a need to seek help, it seems that IH is a potential issue here. It relates to the internalised uncertainty of whether IPV is part of the 'territory' of MSM relationships. Recent research shows an association between IH and lack of disclosure of IPV among gay men (Finneran, Chard, Sineath, Sullivan, Stepheneon 2012)

#### *External structural barriers*

Men in WS3 and WS1 faced the more practical and structural barrier of a lack of knowledge or understanding as to where they might try to seek help from formal sources. This lack of knowledge contrasts with women's lack of autonomy, seen in women having their partner [and perpetrator] accompany them to consultations.

#### **Facilitators**

The synthesis developed two main over-arching third order constructs which relate to the gender of the study participants. Studies with women are involved in a process of disrupting the structural barriers whereas studies with men are involved in a process of validation through reciprocity.

### *Disruption of structural barriers*

Perhaps unsurprisingly, IRIS, LARA and PATH (all studies with women) shared similarities in relation to the factors that facilitated the help-seeking process. These we found to be external factors – elements from ‘outside’ the participants which prompted a desire or need to seek help and which served to disrupt the internalised structural barriers. Thus, tangible or practical issues such as severe physical abuse (which may trigger an internal decision-making process), the needs of children, or being provided with information and asked questions about abuse could facilitate or force women to overcome barriers to help-seeking. In contrast, men showed different reactions to serious incidents. Although one man (WS3: 60) did experience serious physical abuse and the police were called, he did not consider seeking formal support from them. Instead he chose to leave the relationship. Similarly, another male participant (WS3: 61) sought medical help after being punched in the eyes. Incidents of severe abuse did not appear to be linked to help seeking through a disruption of structural barriers. On the contrary, neither participant perceived themselves as having been in an abusive relationship, though one man chose to leave their relationship.

### *Validation through reciprocity*

The situation for the men in WS1 and WS3 was somewhat different. Men in both groups were less likely to have sought help at all for IPV. The key factor to incentivise help-seeking was the opportunity to validate their own experiences through reciprocal disclosure. Although rarely seeking help from formal sources, men were more prepared to seek informal support from friends (and to a lesser extent, family) although as noted above, the support required tended to be more in the form of non-challenging debate rather than advice.

### **Informal support: Family and friends**

All five studies indicate that there is an element of risk assessment in the decision to seek help. The five studies divide into two internally consistent groups in relation to how this risk assessment manifests. For studies with women the process of risk-assessment involves protection of self and others, for studies with men the process of risk-assessment involves a validation of the self.

### *Risk-assessment: protection of self and others*

In relation to IRIS, LARA and PATH this risk assessment can be associated with considering the risk to self (preventing further abuse) or the risk to others (endangering them by telling them about the abuse or, conversely, failing to protect them by not telling anyone). A woman victim of IPV considering telling family or friends about her situation often finds herself forced to ‘weigh risks to herself against risks to them’ (Teays 1998).

### *Risk-assessment: defining the territory of IPV for men*



For men in WS1 risk assessment did not relate to the risk of preventing further abuse or protecting others – but rather defining the territory of IPV for men. One study found that men in heterosexual relationships who experienced IPV sought help from a variety of sources but were most satisfied with the help they received from family and friends (Douglas, Hines 2011). This was complicated for the men in our studies who were in same-sex relationships. They resisted help-seeking if it meant explaining aspects of their relationships to heterosexual family and friends because it meant having to define the uncertain territory of IPV within same sex male relationships. There might also be a reluctance to acknowledge a failed relationship because of an inherent need to show that a gay relationship works. This is discussed in the wider literature in terms of IH and the perceived double stigma associated with being gay and a victim of abuse: “gay men experiencing violence may also experience a “double closet” of learned social shame of homosexuality [alongside] shame of victimhood, making them less likely to seek out IPV support” (Balsam, Szymanski 2005, p.269).

### **Health professionals**

The synthesis identified two different processes of validation that mapped onto whether the studies involved women or men.

#### *Looking for validation (that behaviour is abusive)*

In many cases, women in IRIS, PATH and LARA were not sure if they were experiencing abuse at all, or if their partner was ‘just’ bullying them or the abusive behaviours were a normal feature of relationships. To a large extent, these women had been looking for their experiences to be acknowledged and validated. Research has noted that being asked about abuse by health professionals ‘may signal to a woman that it is unacceptable and that her feelings about it are valid’ (Roberts, Hegarty, Feder 2006).

#### *Validation of masculinity and sexuality*

The situation for men in WS1 and WS3 was different. First of all, they were less likely to have visited their GP at all for issues relating to IPV. For men in WS3, help-seeking from healthcare professionals seemed almost a non-issue because they simply would not consider raising the topic where they may then have to discuss their sexuality or for heterosexual men, have to discuss something that was ‘deeply personal’. In hypothetical discussions about help-seeking gay men indicated that they would feel more comfortable seeking help in GUM clinics than in GP surgeries as they could assume that the nature of same-sex relationships would be understood and they valued the anonymity. For these men, any validation of experiences of abuse must first be proceeded with a validation of masculinity and sexual identity, ultimately a validation of the territory of IPV in the context of same sex relationships. Whereas men in WS3 refer to the uncertain ‘territory’ of gay relationships, the literature theorises this

in terms of the heteronormativity of IPV and the double stigma inherent in IH (Finneran, Chard, Sineath, Sullivan, Stepheneon 2012).

#### *Different stages in the abuse journey*

An explanation for why women in IRIS, LARA and PATH were in a process of 'validating abuse' whilst men in WS1 and WS3 were in a process of validating masculinity and sexuality may be that the men in these studies are at different stages of their 'abuse journeys'. Women in LARA, IRIS and PATH had received some form of interaction relating to their abuse from health professionals, albeit after many years of abuse. These women were at a stage where they had been able to recognise their abuse and had others acknowledge it. However, men in WS1 and WS3 had had fragmented contact with informal or formal services and did not always define their own experiences (or those of their partners) as constituting IPV. Whereas most were able to confirm that they would seek help if needed, the issue for many of them was that they did not perceive themselves as needing help in the first place.

#### **Conclusion**

This meta-ethnography has highlighted that gender influences help-seeking in distinct ways. Our findings also suggest that sexuality may be as important as gender in influencing help-seeking but more research is needed. This meta-ethnography has confirmed findings in extant research regarding help-seeking in relation to IPV, for example by highlighting the difficulties that some men experience in seeking help at all and the barriers experienced by women in disclosing to health professionals if not directly asked appropriate questions. However, in drawing together data from five related studies across differing external contexts (general practice, sexual health clinics, mental health services, domestic violence agencies), this meta-ethnography has also drawn attention to the fact that those experiencing IPV are not a homogenous group and that wider contexts, gender and sexuality all influence help-seeking in distinct ways. This is not to suggest that there are not, at times, similarities in help-seeking barriers or facilitators. For example, as discussed earlier in this article, the way in which women interpret their own experiences of IPV has an impact on whether and from whom they seek help. Similarly, this meta-ethnography found that many of the men interviewed for the studies included here did not necessarily interpret their own experiences as either perpetrating or surviving IPV and so were less likely to be able to attempt to identify appropriate sources of support.

In terms of key differences identified by this meta-ethnography there were, for example, stark delineations between formal and informal sources of support for men and women. In terms of informal sources of support, men (in particular, those from WS3) were found to be more concerned to protect their privacy and thus less likely to want to confide in friends and family. Women, on the other hand seemed to perceive available sources of support including both formal and informal as a 'package' of support potentially available to them. Whereas this did not necessarily mean that they

were equally likely to actually access both forms of support, they did seem more likely to have made a conscious decision as to whether to access informal or formal support (or both). Specifically in relation to formal help-seeking from health care professionals, this meta-synthesis found that women favour help-seeking from primary care which is familiar and where they are known, whilst gay men in WS3 favour help-seeking from GUM clinics where there is more anonymity and a taken for granted acknowledgement of their sexual identity. These differences in gender and sexuality therefore suggest that an intersectional approach to understanding the impact of IPV is needed. Whereas the impacts of IPV may not necessarily differ to those in heterosexual or same-sex relationships, it is the social and cultural frameworks that provide recourses to support that treat them as different (Donovan, Hester 2014). This seemed apparent in relation to the men in WS1 and WS3 who perceived more barriers to help-seeking compared to women and with gay men in WS3 being less able to consider turning to formal sources of support than men in WS1.

### **Limitations of approach**

The main limitation in the approach adopted here is that although our analysis revealed striking commonalities and differences on the grounds of gender and of sexuality, we had insufficient data to be able to look at women in same-sex relationships. If we had been able to separately analyse details from women in same-sex relationships across IRIS, LARA and PATH, this may well have provided a useful additional perspective on help-seeking and service provision.

In terms of methodology, an often cited limitation of meta-ethnography is that it is neither desirable nor feasible to conduct synthesis across studies when each study represents a unique context. In our use of meta-ethnography, the differences in external context (e.g. sexual health clinics versus primary care services) as well as differences in internal contexts (gender and sexuality) have become the focal point for exploring differences in (help-seeking) practice. In other words we have turned a point of potential limitation into an axes of critical interpretation.

### **Recommendations for policy and further evaluation**

The key recommendation emerging from this meta-ethnography therefore is that formal sources of help for IPV need to be provided in different formats for men and women and also taking into account sexuality - for example focusing services for gay men within GUM clinics and services for women within primary care. The data examined here also highlights the need for further research. For example, it is clear that more education is needed in order to overcome the normalisation of IPV in both heterosexual and same sex relationships. In this meta-ethnography, men tended to turn questions on help-seeking into hypothetical discussions irrespective of their own experiences. This could have been

because of the stage they were at (i.e. these men had not explicitly sought help for IPV) but may be to do with differing understandings of the impact of IPV. Again, more education around the impacts of abuse might help men to develop a more informed understanding of their own behaviours. However, further research on the help-seeking strategies of men who have explicitly sought help for IPV may shed further light on their understandings. Men had little knowledge of the specialist services that might provide help to men in abusive relationships. There should, therefore, be improved awareness of those that currently exist.

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